

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PRIMARY CARE PROVIDER STUDENT LOAN REPAYMENT PROGRAM APPLICATION PART A

Please type or print all information

SECTION I: **Personal Information**

1. Name _____ 2. _____ - _____ - _____ 3. Today's Date: _____
Last First Middle Social Security #

4. Are you an American citizen? _____ Yes _____ No

5. Address _____

City State Zip Code

6. Telephone Numbers:
Home () _____
Cell () _____
Work () _____
E-mail _____

7. Do you wish to authorize a spouse or relative to discuss your application in your absence? _____ Yes _____ No

If yes, please print the name of this person: _____

8. RACE: Please mark ONE box to indicate the race group which applies to you:

- A ☐ Hispanic D American Indian, Eskimo or Aleut (AIEA)
B ☐ White (except Hispanic) E Asian or Pacific Islander (API)
C ☐ Black (except Hispanic)

NOTE: If you leave this question blank, a race will be selected for you to satisfy federal reporting requirements. If you leave this question blank but indicate specific races in the next question below, it will be assumed that those races apply to you equally.

9. Are you MULTIRACIAL*? _____ Yes _____ No
If you answer "Yes," please mark all of the races below that apply to you, based on the list in Item 5:

- A) ☐ Hispanic B) ☐ White C) ☐ Black D) ☐ AIEA E) ☐ API

*For purposes of this question, you are Multiracial if you have parents from more than one of the broad race categories listed above, or if at least one of your parents is Multiracial.

Please type or print all information

SECTION II: Practice Information (if applicable)

10. Name/Address of Current practice: Work Phone: () _____
Cell Phone: () _____
Work Fax:() _____
Work EMAIL: _____

City State Zip Code

11. County & Township of Current Practice: _____
County Township

12. Is the above practice a (check all that apply):
Public or Not-for-profit Private Agency [501 (C)3] _____.
Migrant Health Center _____.
Hospital Clinic _____.
Offsite Hospital Clinic _____.
Community Health Center (FQHC) _____.
State, county or City Public Clinic _____.
Critical Access Hospital (CAH) _____.
CAH-administered clinic _____.
Community Mental Health (CMH) clinic _____.
State Psychiatric Hospital _____.
State-funded Primary Care Clinic _____.
State Correctional Facility _____.

13. Hours per week served in current practice: _____

14. Start date in current practice: ____/____/____

15. Are you professionally trained to deliver:
a. Prenatal care ____ Yes ____ No
b. Obstetrical care ____ Yes ____ No

If the answer to 15 is yes, approximately how many pregnant women do you serve per year? _____

If the answer to 15 is yes, approximately how many deliveries do you perform per year? _____

Please type or print all information

SECTION III: Educational and Professional Information

16. Name and Address of Medical/Nursing/Dental/PA/Graduate School

City State Zip Code

17. Beginning date of medical/graduate/dental education: ____/____/____

Graduation date from medical/graduate/dental education ____/____/____

18. Name and address of residency/PA/ nursing program:

City State Zip Code

19. Completion date of medical residency program: ____/____/____

20. Please provide the License Number (LN) of the specialty you will be employing in this loan repayment agreement:

Medical LN: _____ Dental LN: _____

Psychology LN: _____ SW LN: _____

Nursing LN: _____ Phys. Assnt. LN: _____

21. If you are not licensed in Michigan, identify: State of Licensure: _____

License Number: _____ Specialty: _____

Please type or print all information

22. Specialty (Please check one):

- ☐ Family Practice
- ☐ Obstetrics/Gynecology
- ☐ Pediatrics
- ☐ Internal Medicine
- ☐ Psychiatry
- ☐ Nurse Midwife
- ☐ Nurse Practitioner
- ☐ Dental
- ☐ Psychology/Social Work /PNP
- ☐ Other (specify: _____)

If you are an OBGYN or CNM: Will you providing prenatal care? Yes____ No____
Will you spend at least 21 hours per week providing
Primary care in an ambulatory setting during normally
Scheduled office hours? Yes____ No____

SECTION IV: Loan Information (Copy this page if you have more than three loans)

23. Please list below, in priority order, all educational loans received during the professional education for which you are eligible to be considered for repayment. Provide lender information.

	Loan 1	Loan 2	Loan 3
Name of Loan	_____	_____	_____
Program			
Lender Name	_____	_____	_____
Address	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Principle Remaining	\$ _____	\$ _____	\$ _____
Academic Period Covered by Loans	_____/____	_____/____	_____/____

SECTION V: Certification

24. I certify that the information above is true and correct

Signature

Date

SECTION VI: Loan Information

26. Please indicate below the geographic area(s) or specific site where you plan to provide services **(if different from your current employer identified in Section II, item 9)**, Also indicate any conditions, expectations, or information relevant to your SLRP placement that should be known when considering approval of this application. If your site has already been approved as a MEHP site, please indicate this. If you plan to work at more than one site, please indicate the name and address of each site where you intend to provide services, and the approximate number of hours at each site. Please be reminded that a SLRP site application must be submitted with this application for all sites where you intend to provide service.